# Transfer Request Form

**If the information on this form is incorrect, please cross it out and write the correct information.**

**Family Member Number: FMN**

**To find a Primary Care Doctor or Dentist *or***
**To see if your doctor participates in a plan:**

- Call the plan's toll free number listed on the Personal Fact Sheet, **or**
- Visit the Healthy Families website at www.healthyfamilies.ca.gov or call 1-888-439-4741

To change plans, select from the available plans listed on the Personal Fact Sheet. Then write the new plan name(s) below:

**Plan Name**

1. **New Health Plan** _____
2. **New Dental Plan** _____
3. **New Vision Plan** _____

We will tell you if there is a change in your premium amount.

If you are changing plans and wish to choose a new doctor, dentist, or optometrist for the enrolled person(s), write the name in the space below:

| 4. Person's Name | New Doctor | New Dentist | New Optometrist |
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**Fill out this question ONLY if you selected the Special Population Plan**

5. I am a seasonal or migrant worker and have been employed in one of the following jobs in the past 24 months:

☐ Agriculture ☐ Forestry ☐ Fishing

**or**

☐ I am American Indian

6. **Resolving Disputes**
If you enroll in certain plans you agree to have certain claims (which may include medical malpractice claims) decided by neutral binding arbitration. Members give up their right to a jury or court trial. The **Healthy Families Handbook** and website at www.healthyfamilies.ca.gov have information about each plan and the arbitration requirements. You may call the plans you choose to find out more.

7. I authorize a change in the enrollment of the person(s) listed above and certify that the information I have provided is correct. I understand that a change in plans may result in a premium change.
**Signature**_____ **Date**_____